

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5660

BIRTH NO. _____		REG. DIST. NO. 251		PRIMARY REG. DIST. NO. 3048		Registrar's No. 49	
1. PLACE OF DEATH a. COUNTY <u>Madaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Sevier</u>			
b. CITY OR TOWN <u>Maryville</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Washington</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles</u>		a. (First) <u>Charles</u>		b. (Middle) <u>Tolliver</u>		c. (Last) _____	
4. DATE OF DEATH <u>Feb. 13-1949</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>April 8-1858</u>		9. AGE (In years last birthday) <u>90</u>		10. MONTHS <u>9</u>		11. YEARS <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Edith Tolliver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Unknown</u>		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture femur &amp; scapula</u>							
DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>g. 90</u>							
19a. DATE OF OPERATION <u>2-1-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fractured femur</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Washington Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan. 28 49 8:00</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>		38	
22. I hereby certify that I attended the deceased from <u>Jan 28</u> , 19 <u>49</u> , to <u>2/13</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>49</u> , and that death occurred at <u>1:35 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W.L. Bauman</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Maryville Mo</u>		23c. DATE SIGNED <u>2/14/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>2/13/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Albany</u>		24d. LOCATION (City, town, or county) (State) <u>Albany Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-19-49</u>		REGISTRAR'S SIGNATURE <u>Bess Holt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chaffard</u>		ADDRESS <u>Albany Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Clifford Burke

Licensed Embalmer No. 3329

P. O. Address Albany Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.